

## NOTES

### Recovery Program Planning Meeting

#### June 25, 2009

**Persons Present** – Jean New, David Gallagher, Consumers; Laura Flint, Beth Tanzman, Trish Singer, Judy Rosenstreich, Bill McMains, Norma Wasko, DMH; Joanna Cole, Cathy Rickerby, NAMI-VT; Anne Donahue, Legislator; Patrick Kinner, VSH.

**Purpose of Meeting** – To briefly review draft documents earlier posted on DMH website related to values statements and initial conceptualization of clinical programming for the SRR. To address specific questions regarding spatial use of the building needed by the architects to develop the initial draft program of space and preliminary sketches by mid July.

**Agenda:**

- Overview of Today's Meeting
- Comments: Minutes (Notes) of Last Meeting
- Review Current Values List and Principles Statements –documents #1 & #2
- Comments on *Core Clinical and Recovery Strategies* – document #3
- Comments on *Importance of Environmental Design* -- document #4
- Comments on *Safety & Recovery* -- document #5
- Address Key Questions:
  1. What is the right size and number of living clusters? What activities will take place there?
  2. How will work spaces be used? What sizes and numbers will be needed?
  3. How will classroom space be used? What sizes and numbers will be needed?
  4. How many comfort rooms will be needed?
  5. What will be the uses of the library? A quiet space or a computer space?
  6. What activities and rooms should be close together and which should not be close together?
- Other items

**Background Information in Response to Question:**

Who will be in the building? Disabled individuals, people with head injuries, people with legal constraints?

A: The population of the SRR will be based on the findings of the state hospital population and service utilization analysis performed in 2008. Findings: Various patient groups matched in terms of diagnoses, functional capabilities and treatment needs on some levels but not on others. One group needed only acute care and left. Their Average Length of Stay (ALOS) was about 60 days. Others needed longer term care, but the community wasn't ready for them. Of these: (1) One group (who became Second Spring candidates) needed intensive care and security. (2) A second group needed security through staff presence (proposed now for Meadow View). (3) A third group were high risk, some assaultive, and dangerous to self or to others. (4) A fourth group was composed of people who are involved in a legal process but the Courts will not release them. The SRR will be designed with a high level of safety and security and will provide recovery services for the latter two groups. The population may include people with

Developmental Disabilities (DD), Traumatic Brain Injury (TBI), and people with Severe Mental Illness (SMI) who are not responding well or consistently to treatment. All will have Severe Mental Illness. And all no longer require acute inpatient unit services.

**Comment:** Of people who are high risk will see TBI, some DD, and will have SMI.

-This population needs secure (locked) space; all will come from VSH. Diagnostic categories cannot rule people out necessarily. Possible exception are people who need nursing home level of care for medical reasons, but have behavioral difficulties.

-Patients who come here will come from VSH. Utilization from there will drive admissions.

-Need to think of program admissions over-time as requiring VSH level of care.

-History of VSH has people stuck there. Hospital should be short term. The SRR is the long term program.

### **Anything Requiring Changes in Minutes or Comments, Additions:**

Brief review by group produced no changes.

### **Review of combined values statements into one list. Also the statutory language that Anne Donahue suggested at June 12 meeting.**

-Are we complying with the statute? Have we left anything out from either document?

#### **Comments:**

Question: What are evidence based interventions?

-Those that research has found effective and have been replicated elsewhere.

-Do these include peer support materials?

-We allow for good practices that have not yet been researched. Not using evidence based practice exclusively.

-If we only used evidence based practice would not be able to do much. (Most of practice has not been empirically tested.).

-Need to add caveat to document #2 (Futures Planning Principles) to include good practices, not committed to evidence based practice exclusive of other approaches.

-Leave "measurable and effective outcomes;" just strike evidence-based.

-The only piece from original legislation that is missing is "privacy and confidentiality"

**ADD:** Privacy and confidentiality are respected and enforced.

### **Brief discussion of documents**

Today --- use papers as guides; will have opportunity to review in greater depth later.

Today just want initial comments.

### **Document #3 - Core Clinical & Recovery Strategies:**

#### **Comments:**

-Two book marks for later discussion: There are multiple sources for these documents – some are controversial, for example: (1) "Illness self management and recovery" vs "consumer directed self management," and (2) Wellness Recovery Action Plan vs Advanced Directives. Need to address this.

-Assessment section is good; captures current models.

-No reference to developing crisis plans with patients. Should go with treatment plans.

**Document #4 on *Importance of Environmental Design*****Comments:**

- Few minor changes from last couple discussions in Architectural Group. Example: laundry facilities being something for entire facility rather than in separate clusters.
- Agreed that laundry facility would be designed so that residents could use it themselves, just not one in each cluster.
- Will have more detailed conversation about number of rooms later? A: Yes.

**Document #5 on *Safety and Recovery*****Comments:**

This document is just the beginning of a conversation that will require considerable thought.

- This incorporates a lot of the Seclusion & Restraint Reduction principles that VSH already working on? A: Yes.
  - We're trying to think about environmental and programming approach to safety; want a different frame than focus on security. Safety applies to everyone. Needs much more work to develop concept. Don't want to focus on containment.
  - How about a cool down room? Sensory modulation room? Yes
  - The one thing that needs to be addressed architecturally is restraint & seclusion space.
  - Rather not have a quiet room next to seclusion room. Add this to r&s list.
- We want to know if this document going in the right direction.
- Do you have a room to do art work? A: Yes.
- No other comments for now.

**Key Questions Required for Architectural Design Process to Proceed****What is right size and number of living clusters? What activities will take place there?**

Have been thinking about 3 clusters of 4,5,6 beds.

Framework is that this is where people live. Wanted to create smaller sub-grouping of people. Not single rooms off long hall way. Want own bed and bath, not shared beds or baths. Also introduced concept of living space associated with each cluster such that if some people had to have movement contained within the cluster, they would have reasonable access to space and would also have more home-like environment. Would have kitchenette with sitting area in each cluster as well as a living room. Currently each cluster would also have a comfort room. The 6 bedroom cluster could be divided into 3 and 3 bedrooms.

Wanted to think about what would we be doing in clusters? What activities would happen there?

- Mostly for sleeping. Rest during the day if they want to. Should be in other areas for other activities. If they want to visit with family could do so in the cluster.
- Like the reference to living room as opposed to activity room. Says this is your home space. From skills-learning perspective this is home therefore want space that supports activities of home. Have social network if one wishes in home space. Would like to get away from calling this a comfort room. Suggests where people get away. Perhaps it is a place to be quiet, get away from other people, or with one person, versus being in the

living room with other residents of the cluster. Need to talk about the activities that occur in one's home.

- I call it my study at home.
- In the bedroom will there be a reading chair? Call it a suite.
- Want to be sure that bedrooms are large enough to accommodate a chair also a desk and chair
- Would want to have a space there for my computer.
- Concept: This is a place for a smaller scale social group. Part of the recovery process that happens here is learning how to live with, negotiate, relate to the people who share the cluster. The area has to be big enough to accomplish this purpose.
- Want a broad continuum of places where people can go to calm down; there are inherent tensions within the communal function of relating to other people.
- What will be occurring elsewhere? Program rooms close to nursing areas such as a multi-media room, art therapy and music room?
- We are just talking here about the residential spaces. We spoke in earlier meetings about replicating the rhythms of the normal day --- moving from where one lives at home to further away places for work, education, etc.
- We would want to build program and culture within the larger program – small group affiliation would be supported in the cluster by the architectural design.
- The flip side is the risk that if it is too large it will not be home like. This is the place where we have the most ability to make it home-like.
- In looking at the cluster with 4 bed rooms it has 4 bed rooms, a sitting room a kitchenette with small sitting area and a comfort room. In the case of the 6 bed clusters that can be divided into 2's. In the living room there is 200 square feet and the quiet room is 120..
- This is too large.
- This would be 10 by 20 feet –same size as the shared living room.
- This is too large for shared space. Also has implications for other space use elsewhere.
- Whether it is too big depends on how many people would use it.
- For 6 people would be too small.

Let's focus this discussion on what people will be doing in these areas.

- What would people do in a residential area that people could not do elsewhere? What would people be doing privately? What publicly?
- This is why I would be concerned about the suite space being too large, because there are all these other public spaces.
- What will people be doing in private spaces:
  - reading
  - doing homework
- Will they be dining in the clusters? No. There is a dining room. Kitchenettes are for snacks, etc.
- What is it that people would be doing in their private bedrooms at home?
- This would be a good opportunity for people to set their (recovery) goals in the morning. At night review whether /how well they had reached their goals. This could happen within the residence.

- Could assign staff to the cluster. Use sense of sub-community. Have review and discussion with smaller group, not the whole program population. Review what is on deck for the day. Want to be sure that the kitchenette and living room are big enough so that all residents and staff could be there.
- Need to think through what staff might be doing and is there enough space there for them.

### BREAK

- I have a fear that if homespace becomes used for programming, it will impinge on home space and duplicate programming space going on elsewhere. Too much focus on programming in the home will get too complex and too locked-in. Impede movement from one environment to another that we spoke about before. Should see home space as small cozy, not tied to program.

-Continue

-See this as a smaller group of people where programming not going on. Staff would have circulation and line-of sight but don't want active programming going on.

-Have to look at implications for staffing patterns, how to minimize conflicts for residents. The programming side would be where the skills learning would occur about relating to other people.

-When I was talking about reviewing goals for day, would be doing it in bedroom or in kitchenette.

-Would not be replicating functions of large spaces.

-Was referring to getting people focused on own recovery

-The living room would have to be of a sufficient size to accommodate programming in the suite.

-Where do the people who live in this cluster get together with the staff who work with them? In the living room?

-But this is to the detriment of the larger public space.

-But this is important. Need to have space where people who live together can negotiate relationships. Don't want space for every function, but do need to capture this.

-Am in favor of having morning meeting. Not have to be in cluster. But should have it somewhere.

Heard need space to negotiate, just not clear where.

If everyone will be responsible for safety not just staff, what are the implications for space?

-If someone is having a really hard time what is the role of other residents in responding to that? What if someone is really dysregulated?

If building a program where everyone is responsible for safety and resident sees another resident having difficulties and feels responsible for helping, where should staff be? Do they have to be right on top of it? Perhaps should be near but give them a little space.

-Architectural design should permit this.

-Residents might be responsible for directly intervening, but could tell staff that someone needs help here. Build this communal responsibility into the programming.

-Architectural design impacts staffing levels.

- Need line of sight, clusters that are closer from central area to end of hall; people are closer.
- How would we design residential sub-clusters if what we are trying to do is help people who are not safe with self and other people learn how to become safe? Need experiences that permit learning social negotiation . Not having to deal with 15 people at once. Easier to negotiate with smaller numbers of people at one time. Six (6) people are a lot of people, should we not have 3, 3, 4, 5?
- What about people who can't get along with others. They need space.
- Might be easier to negotiate community when not psychotic.
- Talking about 6 in cluster because this permits more flexibility for learning; when people have same difficulties, also requires fewer staff.
- Or two pods of 3 that you can separate.
- I think interesting to see what architects come up with. Sub-clusters of 6 and/or more than 3 can be very challenging. If you have a 5, 6, or 4, one or two suites could open out either into the sub-cluster, or into the central staffed area, permit a one-room suite that could become part of a cluster.
- This is a very different play that creates another option for people who need more space.
- It could be that each of the halls branching from the center or like a cul-de-sac, would be more home-like.
- Can't we have a room somewhere where people could go to be out of the cluster somehow to be alone. This person might need to get out of the cluster.
- Would like to be able to go outdoors to get away.
- We were talking about the building walls providing part of the barrier, the wall would not look like a prison.
- The first meeting of this group said important to have ready access to out doors, have opportunity to walk. We spoke in architectural meeting about Vermont buildings that interconnect house, barn. Passing around *Big House, Little House, Back House, Barn* as an example of this kind of architectural approach.
- Would be important to have maximal freedom of movement to outside within a secure perimeter without having to request permission to go out and is still safe. Architects have been looking at how to do this. Patients keep talking about access to outdoors, also want space to work.
- Can have different levels of security? We have been talking about everyone having access to outside, same levels of security. Might be difficult to provide adequate safety for residents unless access to less secure areas is graded based on individual capacity to use it responsibly.

Do we have enough information about clusters for the architect's purposes?

-Need to discuss comfort rooms to provide feedback to the architects.

**Let's talk about comfort rooms** --- Currently in the design there is one in each of the three clusters. Is this the best place for them, or should they be outside the clusters.

-What is comfort room? A: A place that is soft, comfortable, where there are things that are calming; it is a place where a person can go when upset.

-Does this need to happen in the cluster?

- Certainly should not be located next to the seclusion room. Needs to be a room for people to go to.
- If live in this space and work in another space, there should be at least one in other spaces.
- If there are enough different spaces for people to get away (does not have to be labeled comfort room) both in residential area and work area. ...Don't know that we need a sitting room and a living room and a quiet room in the cluster.
- Comfort rooms are for one person. A sitting room is for more than one person.
- Not saying that it has to be in the cluster, but need a space where people can get apart.
- Don't need it in the cluster? But need it somewhere close?
- What is the difference between the sitting room and a quiet room?
- It's a matter of noise.
- Could the individual go to the public quiet space?
- Have to deal with 15 people.
- Need a small quiet space and the living-room sitting room, but not in the cluster and the work areas.
- Noise level is a problem.
- Having a public space other than a TV room has merit. Need a comfort room to learn to regulate my emotions. Need to have a cluster with comfort room and public sitting rooms or have private sitting room and another small quiet room in the cluster. Whatever the final configuration the solution is: Reduce the number of spaces in each cluster by one.
- Will people have to get permission to leave cluster?
- The entire SRR will be secure.
- Outsiders will not be able to enter cluster unless invited.

For 15 people how many comfort rooms do we need.

- Two – one in work area and another near the residential spaces.
- Comfort room could be near the residential space but not in it. Easily accessible to all 15 residents.
- The tub room and the laundry should also be accessible to all residents.
- We are creating a middle area that all people have access to --- “the little house.” This central area might include some of the cluster wings.

## BREAK

### **Focus on Work, Vocational Training and Education**

How do you work with people, at least at the beginning, whose level of risk requires a secure facility, to make use of supported employment?

- Sometime counselors push employment on certain consumers when employment will threaten benefits based on disability. Volunteer work is an option that should be considered.
- So program should not force people to go into a work program. Offer option that volunteerism is as important as paid work.
- Also need an understanding of what some of the barriers to work are.

As we think about employment, how does that translate into space needs of this building.

- Need to consider the needs of the person
- Your assessment piece should include employment, history of employment; obtain picture of where people are to begin to think about what next learning or vocational opportunities should be. Understand that people want work opportunities at the residence as well.
- How much space would an employment assessment require?
- One or two questions in the assessment process. If someone indicated interest in work, explore further.
- What are the architectural space requirements
- Many people are talking about bringing work activity into the SRR (sheltered workshop model thought of as a positive)
- Need sheds: potting shed, the place to start seeds, the greenhouse option.
- People who graduate from SRR could work in the community
- This is a tricky conversation because limited space.
- How many weavers do we now have? A = 1
- Need a room where there could be interviews.
- We've been talking about three different kinds of work:
  - Work that could be brought in as designated jobs
  - Work that would develop from things people make such as arts and crafts, sell the thing I want to do
  - The work of the residence maintenance that is part of what residents who want to work at this do. This is a clubhouse model.
- Community work might include gardening.
- Because this is not a hotel We are talking about a home.
- What spaces would be needed.
- The third, clubhouse, model would be more a matter of designing activities around work that needs to be done.
- People who want to, could do the cleaning, cooking, meal serving.
- For people who are more interested in outside work, have gardening.
- Need a room where people could work on a computer.
- Could bring in outside work, such as mailings, envelope stuffing.
- That would require a fairly large space.
- Just need a table to do a mailing.
- If the building is set up for WIFI, would you need a dedicated room?
- There may be some people who should not have laptops. Don't want to limit programming because some people should not have access to computers.
- How much class room work would be required for vocational purposes?
- Should be offering classes for workplace skills on an on-going basis (examples):
  - computer skills
  - drafting
- Could bring in outside people to teach vocational skills
- Like the concept of bringing community into the SRR
- Would like peers to come in to the program to talk about life stories of recovery.

- Re: People coming in: In current design have room for volunteers. But could interact with residents in variety of spaces: living room, dining rooms, group rooms, could go wherever they are invited. Would not necessarily have to have separate spaces.
- The entryway should be large enough to accommodate mud room function.
- Agree with bringing people in:
  - Could bring in projects people could make a few dollars.
- What do we need?
- What kind of space will we need for what kind of activities at any given time?
- We will need a wide variability of space use.
- Evidence based literature suggests that spatial requirements for work differ between population group (DD, SMI). Have to be careful not to get boxed into rigid space allocation.
- You are suggesting we need a lit review?
- What you need for an art room for one set of residents might differ from what you would need in an art room for a different kind of population group.
- If we do too much generalization now could box ourselves in.
- Perhaps the message is to have a highly flexible space that can support (for example up to 5 different concurrent activities with staff).
- Means you will need to set aside space for storage for multiple different activities
- Important to plan to have rooms big enough to have multiple storage in the rooms or plan to have a multi-purpose storage room.
- Storage rooms are wonderful insulators for sound.
- Need to design for maximum flexibility and spaces that can be enlarged or made smaller according to the needs of the activities.
- Need to have art room separate from other activity rooms. May want music in there. People can help each other get things out of cupboard.
- Think everyone should have a chore in the community.
- We should promote communal responsibility.
- Would we have people who go out to work requiring space considerations.
- Greater implications for staffing. On the other hand could draw on CMHCs to staff going out.
- Storage is really important. May have to separate out different kind of supplies.
- Need to think about access to building supplies, gardening supplies and tools so that they have access that is safe.

## **Library**

- When people say library what are you thinking: Walls and walls of books and magazines.
- Should probably be considered as a multi-media center.
- But multi-media not quiet.
- Lots of libraries do both quietly.
- Need to think of classes and using library stuff as a type of work.
- Check out materials for personal entertainment in own room.

-One of the things we talked about last time is that learning opportunities occur throughout entire day. Library could function as a place to learn work skills during the day and the evening would serve a recreational purpose.

-People could check out books and disks.

-Do we need to have these at the SRR? Maybe what is required is a way to access the Waterbury library.

-Can use computer to do inter-library loan.

-Waterbury library has been very supportive of the VSH

-People could get GED? Yes, as part of work / education programming

-Library is not the old model of quiet reading, more multi purpose use

-But it should be quiet.

-Use library as place to do silent work. People should be able to access it from the residential side. This could be a common, bridging room.

### **Kitchen and Dining Area**

-Is the kitchen family friendly?

-Needs to be commercial grade – prepare meals for 15 plus people, but that residents will have access to the kitchen and have access to a smaller residential type stove and counters.

-The dining would be communal. Large central kitchen. People would be supervised wherever they are; expect that residents will be in the “real kitchen” use smaller stove as part of their educational / learning purpose.

-Thinking of example where the Chef owns one side of the kitchen island, family and residents worked on the other. Worked well.

-We have more work to do to develop the safety issue.

-The original idea was that the kitchen would be locked when not staffed.

### **Over-all Concept of Space for Work, Education and Training Purposes**

Concept seems to be to concurrently run multiple different activities of small groups --- e.g., 3 residents with staff and 5 running concurrently. Probably not going to have 10 residents involved simultaneously any one activity; probably not going to happen. Might have groups of 5.

-In last meeting we talked about group rooms large enough to accommodate 10 + people.

-We have 2 (one large and one small) group rooms; an activity room, a class room that can accommodate 12 people, also library, chapel, interview and consult rooms. Need to go back and test how this fits current program of space.

-This drastically exceeds the max square footage.

-I count 5 spaces.

-It's a question of the total square footage. We are considerably over

-This will push the budget way over.

-How about have big spaces that can be subdivided?

-Depends on definitions. The large activity room was 20 x 20 = 400 square feet.

-The dining room accommodates 30 people 660 sq f.

-We could flexibly divide the activity room. Perhaps combine several existing larger space rooms for total overall reduced footage, but permit larger sub-divisions within this area.

### **Seclusion & Restraint Rooms**

Culturally and clinically a key program objective of the SRR will be zero use of the S&R room. However it seems we will need the S&R capacity to exist. We will need to have more conversations about programming to achieve this objective as recovery planning proceeds.

-What currently happens now at VSH? Brooks Rehab currently has none. Need to get information about what is currently happening now.

-How many rooms do we need?

-Could S&R serve multiple purposes?

-What is the size: 300 square feet total.

-I think that we could use a quiet room to calm people down. Not need S&R.

-I (am a consumer) have worked in a hospital. You will need probably 2 S&R rooms for safety sake.

-Might we need then 3? If situation becomes that acute, shouldn't the individual go to the hospital.

-But may need the extra room to keep everyone safe until we get the individual to the hospital

-Do we want to sacrifice the idea of home?

-Given the size requirements and functional requirements of an S&R room, could we make do with one and two comfort rooms.

-Yes, one of the reasons for two comfort rooms is so that you catch someone before they get to that point.

-Why should we assume it takes so long to get the individual to the hospital?

-Takes 5 – 10 minutes --- in meantime need to keep people safe.

-What happens at Second Spring?

- Need to understand all of the other aspects. Would presumably be much more frequent occasion to confront in SRR.

-Presuming that both Second Spring and Meadow View (6 bed staff secure residence) would have situation where person is out of control and needs to be contained. What happens? A: They don't have Seclusion Room, call ambulance.

-That's why 2 rooms are required.

-It is very upsetting when individual is in conditions of S&R; this is a failure of treatment. Want it to happen as quickly and safely as possible. Procedures should be in place to treat this as a sentinel event requiring intensive staff (and resident) debriefing to prevent re-occurrence.

-Though we would plan for zero use, the capacity to have it means that the SRR will be able to accept people with extremely dysregulated behavior that referring entities might otherwise hesitate to send.

-Seclusion and Restraint history should not be a reason for excluding people from the program.

-Challenge: The location should be close to residents and staff.

-We will return to this discussion in future meetings.

We are out of time. Thank you all. Think we have addressed the questions sufficiently for the purposes of the Architectural Programming Group that will meet next on July 13 to address refinement & initial validation of architectural models. The meeting will take place from 10:00 a.m. to 1:00 p.m. in Stanley Hall Room 100, Waterbury Office Complex.

**Next Meeting of the Recovery Program Planning Group: September 15, 10:00 a.m. to 1:00 p.m., Corrections Chapel Conference Room, Waterbury Office Complex.**

**The agenda will address:**

- Role of Peers
- Trauma-specific practices
- Skills for daily living and recovery

DMH will send out a reminder e-mail with the link to session materials on the DMH website in advance of the meeting.